Community Hospital Task Force II
Meeting #7 Notes
February 27, 2008
Rhode Island Department of Labor and Training
Main Conference Room, Building #73, Pastore Complex, Cranston

Commissioner Koller began the meeting and reviewed the agenda.
With regard to modeling the APR-DRG system for Medicaid, the Task Force is examining the implications for Medicaid, the impact on community hospitals, and its potential use in the commercial payer setting. Also on the agenda is options for incorporating a pay-for-quality element to the methodology.

Updates:

- Since the last CHTF meeting, DHS has met with hospital CFOs.
- CFO role is to fact-check the hospital-specific numbers.
- They will also have a role in consulting with the DHS internal workgroup as they go from the CHTF's policy direction to a more detailed design of Medicaid payment methodology using APR-DRG.

- Other concerns raised by the Hospital Association of RI in their Jan. 22nd testimony to the CHTF will be addressed in a meeting on Feb. 29th with hospital CEOs and Lieutenant Governor.
- Similar issues were also addressed in the report from New Jersey about their hospitals, e.g.: the design of the hospital system, reimbursement issues, hospitals' relationship to physicians and outpatient services.
- There is an appetite for talking about the design of the hospital system, and we will talk to the hospital CEOs about what the structure for doing this is, once CHTF wraps up its work on financing.

Question raised by Task Force member – is the future of the Task Force uncertain?
Response: Tried to keep this round of CHTF meetings on financing, as per charge.
Follow up comment: The question is really "what are we financing? Which hospitals?"
Question posed back to the CHTF – what's the Task Force's idea on how to conduct this system design work?

Commissioner Koller stated that the question to the Task Force on the table today is how an APR-DRG system could be adjusted for Medicaid and commercial payers to meet the needs of each type of payer and community hospitals. At the next meeting, the Task Force will be asked about the advisability of applying the APR-DRG and adjusters to commercial and RIte Care as payers.

Question: Could the cost and reimbursement report now in draft form be distributed and considered part of the Task Force's background materials? Response: Need to check with the Department of Health (author of report.)

Pay-for-Quality discussion
Kevin Quinn of ACS, Inc. presented to the Task Force. The main question is, how does a payer operationalize the concept of pay for quality in a way that is fair, appropriate, feasible, and that is not place undue burden on the hospitals.

Payer interest in P4Q is not just about minimizing errors, but also in improving quality. Some initiatives including hospitals' not charging for certain "never events."

Medicare – beginning 10/1/08 – will not pay for certain preventable complications.

Policy decisions to be made – look at what other initiatives do, and have a discussion of what RI can do.

What measures?
Medicare: Proposed measures for P4Q – many are already reported by hospitals.
Arkansas: Adopted some Medicare measures. Hospitals that qualified for payment improved more than hospitals that didn't qualify for payment.
Pennsylvania: Developed measures, already had data.
Rhode Island: Already reports some measures. These measures apply to about 10% of all hospital discharges. Current thinking is to use the Health Care Quality Steering Committee to determine next step on which measures to use in P4Q.

What population? Recommendation/current practice is to look at measures for whole population.

Pay for attainment, improvement, or both?
Medicare has a detailed methodology to pay for both.
Arkansas pays for attainment or improvement, but have to attain or improve on at least 2/3 of measures.
Pennsylvania: Rewards attainment.

How is it funded – budget neutral or new money?
Rhode Island will be budget neutral. RIte Care already pays out $1 million in quality payments to health plans.

Concern raised by Task Force member – cost of administrative overhead to program.
Additional TF member comment: Another quality measure could be the use of rapid response teams, such as those being implemented at Lifespan.

Steve Lonardo of BCBSRI stated that from a payer perspective, there is now lots of activity, whereas previously lots of these P4Q programs were home-grown. Payers find value in others' expertise on measures – there are lots of measures out there. Principles that they would advocate would be to make sure the program isn't burdensome; work collaboratively with hospitals; in the beginning, look at improvement.

Chris Koller asked the Taks Force about their recommendations about using measures reported by the Dept. of Health.

Task Force member: Should consult with hospitals and work with the expertise there – what is onerous and what is not?

Kevin Quinn: Hospitals can also give clinical feedback on what measures make sense.

Task Force member: Taking 3% out of funding pool weakens some institutions and hurts their ability to maintain quality.

What about using P4Q as a revenue enhancer?

Another principle suggested – put something in place that reinforces value of collaboration and learning from each other, rather than competition between institutions.

Chris Koller suggested that the next steps are to identify a group to help devise policy (could be Health Care Quality Steering Committee) and to have DHS work out the technical design.

Question about the Health Care Quality Steering Committee – are hospitals represented on that group? Response: Yes, have a hospital subcommittee, and there is a hospital representative on the Steering Committee by law. Usually, subcommittee does work, and Steering Committee reviews and approves.

Suggestion made for DOH to meet with hospitals' quality staff as first step.
Additional suggestion that RIte Care and commercial plans also be invited to design meeting, because there should be alignment across P4Q programs.

Comment: There's been a commitment to quality by hospitals, and hospitals have been transparent on performance. What more do you need?
Comment in response: Need hospitals' commitment, and transparency, and financing to get it all done.

Financial modeling of 2006 Medicaid payment data using APR-DRG grouper methodology

Chris Koller began this discussion by asking for the Task Force's thoughts on appropriate adjusters to the APR-DRG, keeping in mind Medicaid goals, community hospitals, and commercial and RIte Care applicability (understanding that these are sometimes conflicting.) When making adjustments, you move money around. Another feature that has been added for this presentation is what Medicaid payment would be relative to costs.

Kevin Quinn began the presentation with the caveat is that this is not a Medicaid proposal, but an example.

Kevin then gave an overview of the process to date. ACS has given each hospital a CD with a spreadsheet of the claim-by-claim information in the dataset.

The reason to look at pay-to-cost ratios is because hospitals provide access to Medicaid beneficiaries for reasons related to mission and margin. Hospitals look at pay-to-cost ratios for different lines of business, and payers need to be conscious of that.

Haven't provided hospital-specific estimates because they are still subject to change.

Question raised – why aren't medical education costs included in the cost estimates?
Response: We are estimating the cost of each stay. We used the worksheet in the cost report that shows the cost:charge ratio for different types of services. These ratios exclude the cost of medical education, because it is a conceptual question as to whether it should be considered as cost for individual patient care. We don't know yet if it makes a big difference.

Data presented include a policy adjuster that affected 2400 stays. Policy adjuster was made to mental health and neonate stays based on ensuring access to these services for Medicaid beneficiaries.

Comment from Task Force: Can we put in an adjuster for community hospitals? Another comment – can we put one in for medical education?

Kevin Quinn: Another option is to adjust the base price for community hospitals. Kevin emphasized that one of the advantages of using a DRG-based payment system is that payment is known in advance.

Question – what's overall pay-to-cost ratio? Response: 108% (excludes DSH)

Observation from TF member – concern about impact on pediatric care and impact on hospitals that care for children.

Comment: Anyone who wants to make a case for a policy adjuster needs to be explicit about taking money away from others.

Comment: Task Force might recommend that commercial payers also use APR-DRG, but chooses its own policy adjuster.

Comment: Transition to APR-DRG makes the base price very transparent – and it is evidence-based to some extent, and political to some extent.

Comment: At least the maxi-cap (current) system is predictable – it is simpler.

Question posed to Task Force: What does Task Force think about the policy adjuster in the simulation?

Comment: Neo-nates and mental health services need an adjuster; hospitals should have a voice about how this affects them.
Comment: Looking at historical pay-to-cost ratios may not be fair – so don't necessarily need to restore payments (i.e., it shouldn't be the goal of policy adjusters to match historical payments exactly.)

Question: What methodology is better for matching costs? Current methodology or APR-DRG? Response: Interesting question…

Question Is there data to show how RI's community hospitals fare compared to hospitals nationwide? Response: Nationwide, Medicaid pays under 100% of cost – about 90% *including* DSH payments..

Comment: Need to look at whether hospitals are efficient first – this analysis assumes that costs are reasonable.

Comment: Medicaid has fairly good payment on inpatient side. Public should know that this is just inpatient data, otherwise, they would wonder why community hospitals are in financial trouble.

Question: What's the relative priority of competing goals for Medicaid? Maintain Medicaid access, or correct inequities to hospitals system-wide?

Comment: APR-DRG is better with policy adjusters.

Comment: This is one tool to maintain community hospital viability – to the extent that we implement policy changes that reduce payment, we are not doing that.

Comment: We can see that having specialty services enhances hospitals' ability to negotiate with commercial payers – so, Medicaid can worry less about access in this case.

Comment: We are not dealing with total reimbursement to community hospitals – we can vary this in the future as we see its effects relative to other payers.

Chris Koller asked what the Task Force would think of a policy of "do no harm" to community hospitals as a group? Could do it specifically for community hospitals, or as it relates to essential services. It would be possible to tweak the base prices for community hospitals to achieve this.

Response: Received favorably. This proposal is consistent with examining issues related to community hospitals. Comment made that if Medicaid is going to redistribute, it should be done to drive quality, efficiency, and access.

Next steps

- Next meeting agenda item: Is there a desire to have more discussion about applicability to commercial insurers? What are advantages and disadvantages.
- Once this discussion occurs, current CHTF charge is met.
- At next meeting, CHTF members will be asked what they think are the next steps.

CHTF member had 2 suggestions: 1) Get updated financial information from hospitals to review at the next meeting to understand the urgency of their financial situation; 2) Make a chart of issues that are most important to community hospitals (financial issues are some, but not all.)